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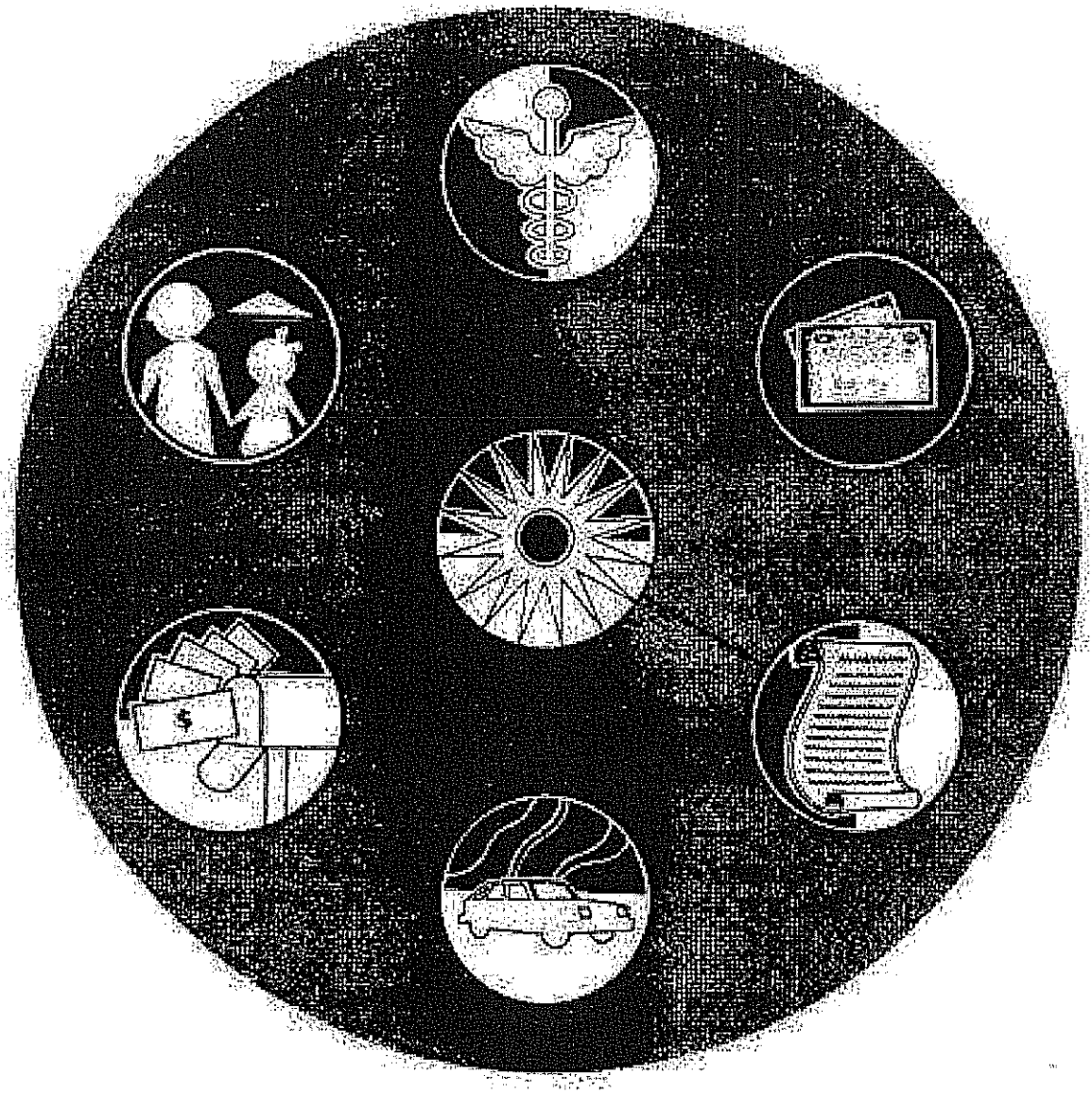

YOUR BENEFITS IN RETIREMENT

For General Motors Salaried Retirees
And Eligible Survivors

As a General Motors salaried retiree eligible to receive benefits under the GM Retirement Program for Salaried Employes, you have one of the finest, most comprehensive retiree benefit programs in industry. This booklet is designed to answer your questions concerning the ways in which your GM benefits can help you and your eligible dependents. ***It should be kept available as a reference source to answer your questions.*** The booklet also discusses Social Security benefits in general terms. The information in this booklet will help you to understand the protection available to you as a GM retiree and to your eligible survivors.

Information in this booklet applies to GM salaried retirees and their eligible dependents. This booklet does not apply to individuals who terminated their employment with GM prior to being eligible to retire but who may be eligible to receive a deferred vested retirement benefit.

Some, but not all, of the information in this booklet also applies to the eligible surviving spouse of a deceased employe or retiree. Information applicable to eligible surviving spouses is so noted in the text of the booklet.

After reading this booklet you may have a specific question which is not answered. If so, you may wish to contact the salaried personnel office at the GM location where you or your deceased spouse last worked or in the event the location has closed, the location which now handles your records.

Each of the benefit programs has its own terms and conditions which in all respects control the eligibility and payment of benefits mentioned. The payment of benefits is conditioned, of course, upon your eligibility to receive them.

From time to time you may receive information concerning changes in your benefits. You may wish to keep the information you receive with this booklet so that you always will have up-to-date information concerning your benefits readily available.

General Motors Corporation reserves the right to amend, change or terminate the plans and programs described in this booklet.

How To Find The Information You Want

If you have a specific question about your retirement, health or life insurance benefits, you may wish to contact the salaried personnel office at the GM location where you or your deceased spouse last worked. For your convenience, the correct location is shown on the stub of your monthly retirement check.

Your Retirement Income

Any retirement benefits you may be eligible to receive as a GM retired employe or surviving spouse are based on the provisions of the Salaried Retirement Program in effect when you or your deceased spouse retired. However, the benefit amounts may have been increased from time to time depending on the date you or your deceased spouse retired.

Your GM Retirement Program is made up of two parts—Part A and Part B.

Any Part A benefits which you may be receiving are non-contributory. The entire cost of providing these benefits is paid for by GM. The benefits provided under Part A of the Program are comparable to those provided under the hourly-rate employes' pension plan.

Any Part B benefits which you may be receiving are in addition to any Part A benefits which you may be receiving. To be eligible for Part B benefits you must have contributed while eligible and left your contributions in the Program until retirement. Part B consists of two components—primary benefits, which are based on the amount you contributed, and supplementary benefits, which are based on your average salary at retirement. While you must have contributed in order to have participated in Part B of the Program, GM pays the entire cost of the supplementary benefit and most of the cost of the primary benefit.

Further information regarding benefits which may be payable to your surviving spouse in the event of your death begins on page 31 of this booklet.

Retirement Program benefits generally are in addition to Social Security benefits (see page 10). References to Social Security in this booklet are based on the federal law in effect in January 1985. Any questions you may have regarding Social Security should be referred to your local Social Security office.

Below are answers to questions which have been asked by retirees and surviving spouses. If you do not find answers to your specific questions, you may wish to contact the personnel office at the GM location where you or your deceased spouse last worked. Where a GM location has been closed you have been informed of an alternate GM location to contact with your questions. If you are unaware of this new location, it is noted on your monthly retirement check stub.

What Determines the Amount of My Retirement Benefits Under Part A of the Retirement Program?

The items used in the calculation of your monthly Part A retirement benefit include the following:

- Type of retirement
- Date of retirement
- Benefit rate
- Number of years of credited service
- Age at time of retirement
- Whether you elected the Part A surviving spouse option

The information used to calculate your monthly retirement benefit is set forth on your copy of Form SRP-117, Authorization of Monthly Part A Benefits and Part B Supplementary Benefits. This form shows how your retirement benefits were calculated.

A signed copy of this form was given to you or your deceased spouse at retirement.

You are notified of any adjustments to your Part A retirement benefits after you retire by letters showing the revised benefit amounts. These letters should be kept with your Form SRP-117.

What Are the Various Parts of My Part A Retirement Benefit?

Each monthly Part A retirement benefit is composed of one or more of the following:

- Basic benefit (see below)
- Supplement (see below)
- Temporary benefit (see page 5)
- Special benefit (see page 5)

What Is a Part A Basic Benefit and How Is It Determined?

The basic benefit is a non-contributory lifetime benefit payable each month to a retired employe. It also is the amount on which any Part A survivor's benefit is based.

The basic benefit amount is determined by multiplying the basic benefit rate currently in effect by your years of credited service. This benefit may be reduced because of your age at retirement. It also will be reduced if you have a survivor option in effect, or if you had pre-retirement survivor option coverage in effect after August 22, 1984.

What Are Part A Supplements?

Part A supplements are amounts paid monthly in addition to basic benefits. The interim supplement is in addition to the Part A basic benefit. The early retirement supplement and early mutual supplementation are intended to bring your total monthly benefit up to a certain level until you attain age 62 and one month (age 65 if you retired before October 1, 1979).

If you retired between March 1974 and September 1979, you may be eligible for an age-service supplement or a lifetime supplement. These supplements are payable each month for life.

Are Part A Retirement Supplements Reduced for Reasons Other Than Age?

Yes. If you are receiving an early retirement supplement, any increase in your basic and temporary benefits will result in a corresponding decrease in your supplement.

Any supplement payable to you prior to age 62 and one month (age 65 if you retired prior to October 1, 1979) will be reduced for earnings in a calendar year which are in excess of the following amounts:

Calendar Year	Annual Earnings Limitation Amount
	$
1985	7,200
1986	7,600
1987	8,000

For example, if you earn more than $7,200 in 1985, your supplement will be reduced by $2 for each $1 of your earnings above $7,200.

If you retired under the placement and incentive programs between ages 55 and 65, or retired prior to age 60, on or after January 1, 1985 under a Corporation-consent retirement, the early mutual supplementation and/or temporary benefits also are subject to the above annual earnings limitation amounts. In that case, however, such benefits would be reduced by only $1 for each $1 of your earnings above the annual earnings limitation amount.

If you retired voluntarily and become eligible for a Social Security disability insurance benefit, any supplement you are entitled to receive before age 62 and one month (age 65 if you retired before June 1974) will be reduced. The amount of the reduction will equal the amount of the temporary benefit in effect at the time of your Social Security disability insurance benefit award (see page 5).

If you become eligible for a Social Security disability insurance benefit or if you earn more than the amount listed above, you immediately should advise the personnel office at the GM location from which you

retired. This will help prevent an overpayment of GM benefits which you would have to repay.

If you retired between March 1974 and September 1979, with 30 or more years of credited service, you may receive a monthly Part A lifetime supplement of $65.00 per month upon attaining age 65.

Part A supplements are reduced by the amount of any monthly Part B supplementary benefit payable to you.

When Am I Eligible for Part A Temporary Benefits?

If you retired prior to age 62 (age 65 if you retired before June 1974) because of total and permanent disability under conditions mutually satisfactory to you and GM, as a "special early" retirement, or at the option of GM, you may be eligible to receive a monthly temporary benefit. The temporary benefit would be in addition to any Part A basic benefits or supplements for which you may be eligible.

The temporary benefits payable for special early retirements which commenced after February 28, 1982 and prior to January 1, 1985 are discontinued for any month you have outside earnings if you retired from a layoff which commenced prior to your attainment of age 54. Any temporary benefit payable for retirements which commenced on or after January 1, 1985 (except for total and permanent disability retirements) may be subject to the annual earnings limitation referenced on page 4.

The temporary benefit is payable to age 62 and one month (age 65 if you retired before June 1974). In no event, however, will the temporary benefit be payable after you become eligible, or could have become eligible, for a Social Security disability insurance benefit. If you are approved for Social Security disability insurance benefits, the temporary benefit ceases to be payable, even if you subsequently cancel your Social Security disability insurance benefit. The amount of the monthly temporary benefit is based on your years of credited service at retirement, up to 30 (25 for retirements prior to January 1, 1983); and the temporary benefit rate as determined by your retirement date. On October 1, 1984, the amount of the temporary benefit was increased by one dollar per month, per year of credited service, up to 30 (25 for retirements prior to January 1, 1983).

When Do I Become Eligible for the Part A Special Benefit?

Each retired employe and eligible surviving spouse who is age 65 or over and receiving a monthly Part A basic retirement benefit, or a survivor benefit related to Part A, is eligible to receive a special benefit, as follows:

Special Benefit Amount Effective on Dates Indicated		
1-1-85 through 12-1-85	1-1-86 through 12-1-86	1-1-87 and after
$15.50	$17.60*	$19.60*

*Or the Part B "Medicare" premium, if less.

This benefit also is payable, upon application to General Motors, to a retiree or eligible surviving spouse who is receiving a Part A basic retirement benefit and who is under age 65 and enrolled in Part B of Medicare.

This benefit is provided under the Health Care Program for retirements with benefits commencing on and after October 1, 1979, but is included in the monthly retirement check. Not more than one special benefit is payable to any individual for any one month under all GM plans or programs.

What Are the Various Parts of the Part B Retirement Benefit?

Each monthly Part B benefit includes a primary benefit. It also may include a supplementary benefit.

The primary benefit is based on a percentage of your total Part B contributions at retirement.

The supplementary benefit is based on a percentage of your average monthly base salary times the number of years you were a participant under Part B.

What Determines the Amount of My Retirement Benefits Under Part B of the Retirement Program?

Any benefits you may be receiving under Part B of the Retirement Program are based on the following:

- The type of your retirement
- The date you retired
- The number of years you participated
- Your age at retirement
- Whether you contributed at all times while eligible
- The amount of your contributions in the Program
- Your average monthly base salary as defined in the Retirement Program in effect when you retired
- Whether you elected a Part B surviving spouse option

The amount and calculation of your Part B primary benefit is shown on Form SRP-17. Any monthly Part B supplementary benefits are shown on Form SRP-117. Copies of all applicable forms were given to you or your deceased spouse at retirement. These benefits may have been increased from time to time after you retired. You should refer to the most recent notice from GM which shows your benefits before and after the last increase.

If I Did Not Contribute to My Retirement Under Part B, Is the Part A Benefit Affected?

No. Your monthly Part A basic benefit is the same whether or not you contributed under Part B.

What Happens to the Money That I Contributed to Part B of the Retirement Program?

Your contributions and the Corporation's contributions were paid over to the Metropolitan, Aetna and Prudential Life Insurance Companies or other Trustees. These monies are invested and payments are made to you or to your surviving spouse or designated beneficiary according to the terms of the Program.

Do the Monthly Benefit Amounts Increase?

Most retirees have received increases in their monthly Part A basic retirement benefit at various times since their retirement.

For example, an individual who retired with 25 years of credited service at age 65 in 1969 with a monthly basic retirement benefit of $137.50 received $372.50 in October 1984. This is an increase of $235.00, or more than 170%.

Increases for eligible surviving spouses are proportionate to retiree increases.

The Part A basic benefit rate last was increased by $1.00 per month, per year of credited service, on October 1, 1984.

The Part A supplement, temporary benefit and special benefit also have been increased at various times.

The level of monthly Part A supplemental benefits last was increased on October 1, 1984, for retirees with 30 or more years of credited service who were under age 65 on October 1, 1984. The monthly increase was $30, payable to age 62 and one month, and $15 payable between ages 62-64.

Benefits provided under Part B of the Retirement Program also have been increased at various times in the past. Part B primary and supplementary benefits last were increased on October 1, 1984, up to 6%.

Further benefit enhancements are scheduled for retirees (up to $200) and eligible surviving spouses (up to $120) in the form of a lump-sum payment in December 1985 and again in December 1986.

What Should I Know About My Total and Permanent Disability Retirement?

If you retired because of total and permanent disability, your monthly Part A basic and Part B benefits are the same as if you had retired at age 65. Your benefits are based on your credited service, average salary, and Part B contributions at the time of your disability retirement. In addition, if Social Security determines that you are not eligible for disability benefits under the Social Security Act, you may receive a temporary benefit from GM (See page 5).

If you are under age 65 and are receiving a total and permanent disability retirement benefit, this benefit will cease to be payable if you (i) are no longer totally and permanently disabled or (ii) become gainfully employed for purposes other than rehabilitation. In either event, you should notify the GM location from which you retired or the designated location in case your former employing location is closed.

Can I Change My Type of Retirement After My Retirement Effective Date?

No. The type of retirement under which you retired will be retained throughout your retirement years.

May I Assign Any of the Benefits Under the Retirement Program to Another Person?

No. You cannot assign your rights under the Retirement Program to anyone else. However, a court may assign a part, or all, of your monthly benefits under a Qualified Domestic Relations Order.

Can My Retirement Benefits Be Reduced for Workers Compensation I Receive?

Yes. Workers compensation benefits paid to retired employes will be deducted from the Part A retirement benefits otherwise payable. However, for retirements prior to October 1, 1984, workers compensation payments paid under a claim filed within two years after the breaking of credited service will not be deducted.

This deduction also is applicable to any supplementary benefits you may be receiving under Part B of the Retirement Program.

What If My Spouse Dies or We Are Divorced?

If you have a survivor option in effect as discussed on pages 36 and 37, you may revoke the survivor option in the event your designated spouse dies or you are divorced by final court decree, and the terms of the court decree do not expressly prohibit cancellation of the survivor annuity. Generally, your Part A basic benefit would be restored to the amount payable without the option. Restoration is effective on the first of the third month after proper notice and documents are received by GM. Part B benefits are not restored to the amount payable without the survivor option in the event you outlive your spouse.

Approval of GM and/or Metropolitan is necessary for revocation of any survivor option while your spouse is alive.

If I Marry or Remarry After My Retirement, May I Elect a Survivor Option for My New Spouse?

If you retired on or after January 1, 1962 and did not reject the Part A surviving spouse option at any time it was made available to you, you may be eligible to elect or re-elect a Part A surviving spouse option with respect to your new spouse. In all cases the option would provide benefits under the terms and conditions of the program which was in effect at the time you retired.

The option would become effective on the first day of the third month following the month in which your completed election form is received by GM. However, the option cannot become effective before you have been married to your new spouse for one year.

IMPORTANT—*The option will not become effective if your completed election form is received by GM after the first day of the month in which you have been married for one year.*

To elect or re-elect the option, complete Form SRP-60, which is printed on page 45 of this booklet. Just tear out and send the completed form, together with proof of your present marriage, to the personnel office at the GM location from which you retired or the designated GM location.

What If I Return to Work For GM?

Your monthly retirement benefits will cease to be paid to you upon return to work with GM or any of GM's wholly-owned or substantially wholly-owned subsidiaries. Your health care and life insurance coverages provided during retirement also will cease. You may be eligible immediately to accrue additional credited service and be eligible for whatever benefits and coverages are provided at your employing location. GM retirement benefits, health care and life insurance coverages will be reinstated upon your subsequent retirement.

When Will I Receive My Monthly GM Retirement Check?

Generally, retirement checks are mailed by the trustee to the retiree, surviving spouse or a designated bank or credit union three business days prior to the end of each month. Therefore, you should receive your check during the first week of the next month. If you do not receive your check within 10 days from the first of any month, you should contact the GM location where you or your deceased spouse last worked. If you have a banking agreement, you should contact the bank or credit union prior to contacting your former employing location. After you notify the GM location of the missing check, a stop payment will be placed on it. Thereafter, a new check will be issued to you as soon as possible.

What Is a Banking Agreement and Am I Eligible to Have One?

A banking agreement is an arrangement you may elect so that your monthly retirement check will be deposited directly into your bank or credit union account. If you are interested in a banking agreement, ask your bank or credit union if they have facilities for this procedure. If your bank or credit union permits this procedure, contact the GM location where you or your deceased spouse last worked to obtain the required banking agreement forms. You then can arrange to have your monthly retirement check deposited directly into your bank account.

Whom Should I Notify If I Have an Address Change?

You should notify the GM location where you or your deceased spouse last worked any time you change your address. You should notify the GM location of the address change even though you have a banking agreement. A correct home address helps to ensure that you, as a GM retiree or a surviving spouse, will receive information sent to you by GM.

What Information Is Needed to Identify My Particular Retirement File?

Whenever you write to the GM location where you or your deceased spouse last worked, or to General Motors, you should include your CISCO (plant) code-retirement identification number. Your CISCO code-retirement identification number is shown on the check stub of each monthly retirement check you receive. If you do not know your CISCO code-retirement identification number, you should identify the location where you or your deceased spouse last worked whenever you write regarding your benefits.

Are My Retirement Benefits Subject to Federal Income Taxes?

The Internal Revenue Service has taken the position that retirement benefits under both parts of the Program, Part B primary benefits and the trusteed portion of the Program (Part A and Part B supplementary benefits), should be

combined and considered as received under a single plan. Under this position, if the total of such benefits received within three years from the first payment is expected to equal or exceed your contributions to the Program, all benefits under the Program should be excluded from your gross income until an amount equal to your contributions has been received. The amount of your contributions is noted on your copy of Form SRP-117 which was given to you or your deceased spouse at retirement. Once an amount equal to your contributions has been received under the Program, all subsequent benefit payments would be fully includable in gross income.

If the aggregate benefits received within this three-year period will be less than your contributions to the Program, each benefit payment you receive will consist of two parts: (a) a return of your contributions and (b) taxable income. In general, the portion considered to be a return of your contributions, and thus tax free, is determined by multiplying the benefits received by a calculated percentage. The percentage may be obtained by dividing your net contributions to the Retirement Program by the total amount it is estimated (through use of life expectancy tables provided by the Internal Revenue Service) you and your survivor annuitant, if any, will receive under the Program as of the date the benefits commence.

If you are receiving benefits under Part A only (or benefits under Part A and only supplementary benefits under Part B), the entire amount of such benefits will be taxable as ordinary income when received since all of the contributions toward the cost of these benefits were made by GM. If you retired because of total and permanent disability you may be eligible for a special income tax credit.

For further information relative to the federal income tax status of your retirement benefits, you may wish to consult your tax advisor or the instructions for U.S. Individual Income Tax Return (Form 1040) covering pension and annuity income.

What About State and Local Income Taxes?

Your retirement benefits may be subject to state and local income taxes. However, not all state and local jurisdictions impose an income tax on individuals. In addition, other jurisdictions exempt all or a portion of retirement payments from income tax. Because of these differences, you should consider any taxability of your retirement benefits in light of the laws in effect in your particular state and local jurisdiction.

For further information relative to the tax status of your retirement benefits, you may wish to consult instructions for applicable state and local income tax returns, or your tax advisor.

Is Any Withholding of Income Tax Made From My GM Benefits?

Federal income tax will be withheld from your GM retirement benefits unless you request no withholding be made. If you do not wish to have federal income tax withheld from your GM retirement benefits, you must request no withholding on U.S. Treasury Form W-4P or a GM TEFRA-1 Form. Form W-4P is available at your local Internal Revenue Service office. The GM TEFRA-1 Form is available from GM. You should read carefully the instructions for the form before completing it. The completed form should be sent to your former employing location. Once begun, withholding will continue until you request in writing that it be terminated or until you file a new form increasing or decreasing the amount of withholding.

The Retirement Program Trustee and the Metropolitan are required to file Form W-2P (Statement for the Recipients of Periodic Annuities, Pensions, Retired Pay, or IRA Payments) with the Internal Revenue Service with respect to all persons who receive retirement benefits during a calender year. A copy of the form filed with the Internal Revenue Service will be furnished to you.

SOCIAL SECURITY BENEFITS

What About My Social Security Benefits?

Your Social Security benefits generally are in addition to GM retirement benefits for which you might be eligible. You and GM contributed equally to the cost of Social Security benefits. Social Security old-age benefits may begin as early as age 62 in a permanently reduced amount. Benefits are payable in full if they begin at or after age 65.

Your GM Part A basic retirement benefits are not affected by your eligibility for Social Security. However, the early retirement supplements and temporary benefit are reduced, or eliminated, when you become eligible for a Social Security disability insurance benefit. Neither GM nor the Retirement Program trustees will be responsible for any attorney fees you may incur in connection with any disputed Social Security application.

If you retired because of total and permanent disability, under conditions mutually satisfactory to you and GM, as a "special early" retirement, or at the option of GM, and become eligible for a Social Security disability insurance benefit, you should notify the GM location from which you retired. Prompt notification may prevent an overpayment of GM benefits which you would have to repay.

What About Social Security Benefits for My Spouse?

Your spouse may be eligible for a Social Security benefit based on his or her own wage record. If not so eligible, your spouse's monthly Social Security benefit will be equal to one-half of your unreduced monthly Social Security benefit, if your spouse is age 65. Your spouse may receive a permanently reduced benefit as early as age 62. A reduced widow's or widower's benefit is payable as early as age 60.

When Can I Receive Social Security Disability Benefits?

If you are disabled, you may be eligible to receive disability insurance benefits from Social Security at any age before age 65. You should consider applying for Social Security disability insurance benefits for the reasons set forth on page 28. These benefits equal your accrued Social Security benefit payable as if you were age 65. Your nearest Social Security office can tell you if you qualify. Benefits may be payable after you have been disabled for five full calendar months.

If you become eligible for Social Security disability insurance benefits, you immediately should notify the personnel office at the GM location from which you retired. This notice is necessary to avoid an overpayment of GM benefits which you would have to repay.

How Do I Find Out What My Monthly Social Security Benefit Will Be?

Questions concerning Social Security should be referred to the Social Security office nearest you.

The following table shows current maximum monthly Social Security old-age benefits. The table is based on the federal law in effect in January 1985.

Maximum Monthly Social Security Old-Age Benefits for Retirement at Age 65

Year of Retirement	Monthly Benefit Amount		
	Retiree	Spouse	Total
	$	$	$
1951	405	202	607
1955	494	247	741
1960	506	253	759
1965	523	261	784
1970	580	290	870
1975	659	329	988
1980	836	418	1254
1981	866	433	1299
1982	781	390	1171
1983	760	380	1140
1984	729	364	1092
1985	717	358	1075

NOTE: Amounts are rounded to nearest dollar. In all instances, you and your spouse are assumed to be the same age. You and your spouse may receive lower benefits from Social Security than those shown above if you earned less than the maximum amount subject to Social Security taxes or if either of you had not attained age 65 at retirement.

Your Health Care Benefits

The GM Health Care Insurance Program provides protection for you and your eligible dependents against a wide range of health care expenses. The Comprehensive Medical Expense Insurance Program (CMEIP) is additional coverage which provides major medical benefits over and above those available under the basic coverages. GM health care coverages have been changed from time to time through the years and are subject to change in the future. Coverages may be continued for your eligible surviving spouse in the event of your death as described on page 38.

Basic hospital, surgical, medical, prescription drug, and hearing aid coverages are provided through "The Informed Choice Plan" (ICP). Substance abuse, dental, and vision coverages also are provided. Under the Informed Choice Plan, you will be offered a choice, annually, among three health care options, to the extent they are available in your area:

- the Traditional Insurance option
- the Preferred Provider Organization (PPO) option
- the Health Maintenance Organization (HMO) option

These options are designed to provide quality care on a cost-effective basis. ***(It is important to note that some of the alternative plans do not cover Medicare eligibles.)*** Descriptive materials concerning benefits provided under each option are available at the personnel office of your former GM employing location.

If you or any of your dependents are age 65 or older (or are disabled) and are covered under the federal Medicare Program, your coverage under the GM Health Care Program is adjusted automatically on the date the Medicare coverage becomes effective (see page 21).

Set forth below are answers to many questions concerning health care benefits. Although coverages may differ slightly under the various options, in general, covered expenses include items detailed in these sections. If you have any questions concerning your health care benefits that are not answered, you may wish to contact the personnel office at the GM location where you or your deceased spouse last worked. This is a general description only and the provisions of the GM Health Care Insurance Program control.

Are My Health Care Coverages Continued While I Am Retired?

Your basic health care coverages will be provided at GM expense for your lifetime (except for voluntary retirement as early as age 55 and prior to age 60 when combined years of age and credited service total less than 85, or for retirement as early as age 60 and prior to 65 without retirement benefits).

If you retired voluntarily as early as age 55 and prior to age 60 when your combined years of age and credited service totaled less than 85, you may continue your basic health care coverages for your lifetime provided you pay the full cost.

During periods that basic coverages are in effect, you also may continue your comprehensive medical expense insurance coverage by making the monthly contribution applicable to retirees (see page 19) or by paying the full cost, if applicable.

How Do the Informed Choice Plan Options Differ?

The Traditional Insurance option is a basic hospital, surgical, medical and prescription drug program for GM retirees and surviving spouses. It has a predetermination system to help protect you and your family from unnecessary surgery and hospitalization. This option is administered by either a Blue Cross-Blue Shield plan or the Metropolitan Life Insurance Company, depending on the location from which you or your deceased spouse retired.

The Preferred Provider Organization (PPO) is a network of doctors, hospitals and other health care providers. Under the PPO option you can receive all the benefits of the Traditional Insurance option, plus benefits for additional services.

A Health Maintenance Organization (HMO) is a local health care delivery system of doctors, hospitals and other health care providers that emphasizes preventive health care. Coverage provided may vary among HMOs. Generally, in addition to services covered under the Traditional Insurance option, certain preventive and routine health care services are covered. Depending on where you live, you may have more than one HMO from which to choose.

What is Predetermination?

The Traditional Insurance option has prior authorization (**predetermination**) and review procedures to help you and your covered family members avoid unnecessary surgery and services, or unnecessary or prolonged hospitalization. **If you are covered by Medicare, you are not subject to the predetermination requirement.** If your hospital or physician fails to follow the predetermination process, you will not be responsible for charges incurred unless you have agreed to accept responsibility. However, if you are denied prior authorization and still elect to have the services performed, you will be required to pay the first $100 of hospital expenses and the first $100 of medical and surgical expenses as well as 20% of the balance, subject to an annual maximum of $750 per person or $1,500 per family.

The toll-free number from which your physician or hospital can obtain predetermination is printed on your health care identification card. **Predetermination is not required in case of emergency or maternity admission. However, emergency admissions must be reported by your physician or hospital within 24 hours after the admission by calling the toll-free number printed on your health care identification card.**

Are All the Informed Choice Plan Options Available to Me?

The options available to you are determined by the location from which you or your deceased spouse retired or the area in which you live.

In some geographic areas, a PPO or HMO may not be offered. The option available to you will be listed on the enrollment form you will receive annually.

The PPO option is not available to retirees and surviving spouses enrolled in Medicare. If, after electing a PPO, you or one of your dependents becomes enrolled in Medicare, you will have the opportunity to change your ICP enrollment to an option which accepts Medicare enrollees. Should this occur, contact the personnel office at the unit from which you or your deceased spouse retired.

If you are enrolled in Medicare or have sponsored dependents you may not be eligible to enroll with certain HMOs.

You will want to check with the individual HMO relative to restrictions it may have on participation by Medicare enrollees.

To Which Doctors May I Go?

In general, under the Traditional option, you may go to any doctor.

To receive a full benefit payment under the PPO, you must use a PPO doctor (except in cases of referral or in an emergency).

If you are enrolled with a PPO and you incur charges because you choose to go to a non-PPO provider without referral by the PPO, you may be responsible for 20% of the lesser of (a) reasonable and customary charges, or (b) the actual charges incurred, until your

out-of-pocket expenses reach an annual maximum of $500 per person, or $1,000 per family. The 20% payment may not apply in cases of emergency when you (a) are outside the geographic area of your PPO or (b) are in-area but unable to choose a PPO provider.

Under the HMO option, you must use your HMO's doctors (except in cases of referral or in an emergency) to receive benefit payments.

HOSPITALIZATION BENEFITS

What Are My Benefits If I Am in a Hospital?

Hospital coverage provides benefits for the following care and services:

- up to 365 days of needed care in a semi-private room in a participating hospital for general conditions, including maternity care;
- up to 45 days for inpatient treatment of mental disorders (except substance abuse);
- most medical needs in a hospital or approved facility, such as supplies, drugs, dressings, anesthesia, x-rays, laboratory tests, intensive care, and routine nursery care;
- medically necessary transfers by ambulance between hospitals and for transfers from hospitals to approved facilities for a CAT scan;
- up to $180 per day for room, board, and all covered services in a non-participating non-psychiatric hospital (up to $15 per day for psychiatric hospitals); and full coverage for the first five days for emergency admissions; and
- a case management system to identify—and help avoid—unnecessary or prolonged hospital stays. This system will aid those with catastrophic or severe chronic medical conditions, and will be available on a voluntary basis.

What About Hospital Outpatient Services?

Payment is made for most services in the outpatient department of a hospital, such as:

- treatment of accidental injuries and certain medical emergencies, surgery, physical therapy (up to 60 treatments per condition per year, which also may be performed in an approved facility other than a hospital), and use of an artificial kidney machine, iron lung and similar equipment; and
- up to $1,000 per calendar year for outpatient psychiatric services when billed by an approved facility (see page 14).

What Services Are Covered in a Nursing Home?

Up to 730 days of needed care (other than custodial care) are provided in an approved nursing home for general conditions—up to 90 days for nervous and mental conditions (except substance abuse).

Suppose I Need Home Care?

Benefits are provided in those areas which have approved home care programs, including payment made for necessary skilled nursing and home health aides.

SURGICAL-MEDICAL BENEFITS

What Surgical-Medical Services Are Covered?

Benefits are provided for physicians' reasonable and customary charges as determined by the carrier for:

- surgery and anesthesia, including pre- and post-operative care;
- obstetrical delivery, including pre- and post-natal care;
- inhospital consultation and technical surgical assistance;
- inhospital medical care by the doctor in charge of the case and doctor's medical visits at the rate of two per week for up to 730 days in an approved nursing home for general conditions;
- radiation therapy and chemotherapy for malignant conditions;
- up to $25,000 for certain organ transplants;
- laser surgery which replaces the cutting procedure;
- necessary diagnostic x-ray, laboratory, and pathology services;
- laboratory testing for an annual PAP smear;
- outpatient treatment of accidental injuries and certain medical emergencies;
- voluntary sterilization;
- speech therapy for children under six with congenital or severe developmental disorders; and
- outpatient psychiatric services, including family counseling (subject to a copayment of 10% for the sixth through the tenth visits and a 25% copayment for all subsequent visits), and benefits of up to $75 for psychological testing. Payment is limited to $1,000 per person per calendar year in combination with expenses for outpatient psychiatric services in an approved facility.

If you are enrolled in a PPO you also will be eligible for the following services:

- 70% payment for a PPO physician home or office visit by, or on referral from, a PPO physician;
- the first $100 of a PPO physician's fees for well-baby care for children under the age of one; and
- immunizations, by a PPO provider, of children under the age of six against diphtheria, tetanus, pertussis, polio, measles, mumps and rubella.

Are Prosthetic Appliances Covered?

Benefits are provided for the purchase, fitting, and repair of certain external prosthetic appliances which replace a body part or the functions of a permanently malfunctioning body part. These prosthetic appliances must be prescribed by a licensed physician and furnished and billed by a hospital or facility approved by the carrier.

Suppose I Need a Wheelchair or Other Durable Medical Equipment?

Benefits are provided for the purchase or rental of certain durable medical equipment (such as hospital beds, crutches, wheelchairs, portable insulin pumps, home glucose monitors, or bone growth stimulators) when prescribed by a licensed physician. This equipment must be necessary for treatment of a medical condition and be provided and billed by a hospital, nursing home, or professional provider such as a pharmacy or medical supply house.

How Do I File a Claim for Hospital or Surgical-Medical Benefits?

If your carrier is a Blue Cross-Blue Shield plan, just show your identification card when you go to the hospital, residential or outpatient treatment facility, physician, or other provider of covered services anywhere in the country. The hospital or facility is paid directly by Blue Cross for covered services. Blue Shield generally pays physicians directly for covered services. In any situation where a provider of a service is not paid directly by Blue Cross-Blue Shield, you should submit the charges to your local Blue Cross-Blue Shield plan office.

If your carrier is Metropolitan Life Insurance Company, obtain a claim form from the

personnel office at the GM location where you or your deceased spouse last worked, or from Metropolitan. Complete the upper portion of the form and have the hospital, residential or outpatient treatment facility, physician or other provider of covered services complete the lower portion. Either you or the provider can submit the completed form to Metropolitan.

Payment will be made directly to the provider unless you have paid all or part of the charges for service. In that case, Metropolitan will pay the provider and/or will reimburse you the appropriate amount. In the case of hospital coverage provided by Metropolitan, payment will be made to you, unless you authorize Metropolitan to pay the facility directly.

Are Benefits Available for Hearing Aids?

GM health care coverages include benefits to provide hearing aids for retirees, eligible surviving spouses, and their eligible dependents.

To obtain benefits you first must be examined by an ear specialist (otologist or otolaryngologist) to determine if your hearing problem is caused by a condition which may be corrected by use of a hearing aid. **This examination is not a covered service.**

If it is determined that your hearing problem may be corrected by use of a hearing aid, benefits will be provided for the reasonable and customary charges for the following services **only when all such services are obtained from a participating provider** once during any period of 36 consecutive months:

* audiometric examination;
* hearing aid evaluation test (up to $68 subject to change each October); and
* one hearing aid (acquisition cost and dispensing fee). However, only the particular hearing aid prescribed as a result of the hearing aid evaluation test will be covered.

Covered benefits will include an ear mold, necessary fitting and adjustment of the hearing aid, and a follow-up examination to determine the effectiveness of the hearing aid.

How Do I File a Claim for Hearing Aid Benefits?

Participating providers generally will have the necessary claim forms and will be paid directly by the carrier. **Benefits are payable only if you obtain services from a participating provider and only if they are obtained in the appropriate sequence.** Ask the provider if he or she is participating **before** you receive services. If you need the name of a participating provider, inquire at the GM location where you or your deceased spouse last worked, the Blue Shield plan in which you are enrolled, or Metropolitan, as may be applicable.

Does My Coverage Pay for Prescription Drugs?

Benefits are provided for the purchase of drugs which require prescription by a licensed physician under federal law. Benefits also are provided for injectable insulin and disposable syringes and needles when prescribed to inject the insulin. **A $5 copayment is applicable for each prescription order or refill.** (Under the PPO option, your prescription drug copayment will be $3 per prescription.)

Drug quantities are limited to a maximum of a 34-day supply per prescription, except for certain maintenance drugs which may be dispensed in 100 or 200 unit doses. Most pharmacies have a listing of these maintenance drugs. Disposable syringes and needles are limited to a 1-month supply when prescribed with a 1-month supply of insulin or, if greater, 100 syringes and needles when prescribed with a 3-month supply of insulin.

Drugs purchased from a participating pharmacy will be billed directly to the carrier.

If drugs are purchased from a non-participating pharmacy, you will be required to pay the full charge and file a claim with your carrier. You will be reimbursed 75% of the reasonable and

customary charge, less the $5 copayment for each prescription filled by a non-participating pharmacy within the geographic area in which your carrier administers coverage. Prescriptions filled by a non-participating provider out-of-area will be reimbursed at 100% less the $5 copayment. Claim forms may be obtained from the GM location where you or your deceased spouse last worked.

Am I Eligible for the Mail Order Prescription Drug Program?

Yes, if you are enrolled in the Traditional option or a PPO. A mail order prescription drug option is available anytime you have a prescription to be filled. This option can be particularly helpful and cost-effective when you require maintenance drugs over an extended period of time or do not need to have a prescription filled immediately. Under the mail order program, you can expect to receive your filled prescriptions in about two weeks from the time you mail your prescription. You can obtain up to a 90-day supply per prescription for a copayment of $2.

You may request order envelopes by writing to:

Metropolitan Life
MEDI-Met Prescription Drugs
Oneida County Industrial Park
P.O. Box 3018
Utica, NY 13504

Please provide your name, address, social security number and the name and GM location from which you or your deceased spouse retired.

How Do I Receive Covered Benefits for Substance Abuse Treatment?

You will be enrolled automatically for substance abuse treatment only if you choose the Traditional Insurance or PPO option.

Substance abuse treatment is a separate coverage administered by Connecticut General Life Insurance Company. Review and approval prior to receipt of service for all but the first course of treatment by a predetermination coordinator (gatekeeper) is required.

Family Service America (FSA) is the "gatekeeper." A toll-free telephone number to contact in case of questions relating to substance abuse coverage is printed at the bottom of your health care identification card.

For a first course of treatment or, if you are approved for additional courses of treatment, coverage provides payment of charges for:

- up to 45 days in inpatient or residential substance abuse treatment facilities;
- up to 15 days of covered services in a night or day treatment facility; and
- up to 35 outpatient treatments per year in a treatment facility (limited to 140 lifetime treatments).

This coverage also provides payment of charges for up to 72 hours of inpatient admission for detoxification.

How Do I File a Claim for Substance Abuse Treatment?

Claim forms may be obtained from any GM personnel office, or from an FSA agency. If it becomes necessary for you, instead of the facility or provider, to submit a claim form to Connecticut General, you must send the originals of either **itemized** bills, statements, or receipts for each of the medical expenses for which you are claiming payments.

If you are submitting a claim for a second or subsequent course of treatment, **the substance abuse predetermination section of the claim form must be completed by the FSA agency.** Otherwise, benefits for that treatment will not be payable.

Any claims which you are submitting for services rendered on or after April 1, 1985, MUST be submitted before the end of the calendar year following the calendar year in which expenses are incurred.

Is Dental Coverage Included?

Dental coverage is provided for retirees, surviving spouses, and their eligible dependents (except sponsored dependents) for whom General Motors contributes the full cost of health care coverages, regardless of the health care option selected (unless the HMO provides these coverages for GM enrollees).

Benefits will be provided up to an annual maximum of $1,000 per person for other than orthodontics (teeth straightening) during any benefit year (October 1 through September 30), and up to a lifetime maximum of $800 per person for orthodontics for individuals whose course of treatment begins before age 19.

Metropolitan Life Insurance Company is the dental carrier for Michigan retirees and eligible surviving spouses. Connecticut General Life Insurance Company is the dental carrier for retirees and eligible surviving spouses from employing locations outside Michigan. Benefits are based on reasonable and customary charges of all dentists as determined by the carrier.

What Are the Dental Services Covered and the Benefits Payable?

Benefits are payable at 100% of the reasonable and customary charge for:

- oral examinations and prophylaxis (cleaning of teeth), but not more than twice in any benefit year;
- topical application of fluoride for persons under age 20;
- space maintainers that replace prematurely lost teeth for persons under age 19; and
- emergency treatment for temporary relief of pain.

Benefits are payable at 90% of the reasonable and customary charge for:

- dental x-rays, including full mouth x-rays (but not more than once in any period of 36 consecutive months), and bitewing x-rays (but not more than twice in any benefit year);
- extractions and oral surgery;
- amalgam, silicate, acrylic, synthetic porcelain, and composite fillings;
- general anesthetics and intravenous sedation when medically necessary and administered in connection with oral or dental surgery;
- endodontic (nerve and pulp) and periodontal (gum) treatment;
- injection of antibiotic drugs by the attending dentist;
- repair of crowns, bridgework or dentures, and relining or rebasing of dentures more than six months after installation, but not more than one relining or rebasing in any period of 36 consecutive months; and
- inlays, onlays, gold fillings, or crowns, but only when the tooth cannot be restored with an amalgam or other filling.

The remaining 10% of the reasonable and customary charge is a copayment payable by you.

Benefits are payable at 50% of the reasonable and customary charge for:

- initial installation of fixed bridgework;
- initial installation of removable dentures, including any adjustments during the six month period following installation;
- replacement of an existing denture or fixed bridgework, but only when:
  - (a) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or,
  - (b) the existing denture or bridgework cannot be made serviceable and, if it was installed under this coverage, at least five years have elapsed prior to the replacement; or,
  - (c) the existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture; and
- orthodontic (teeth straightening) procedures and treatment (including related oral examinations) for any person whose course of treatment begins before age 19.

The remaining 50% of the reasonable and customary charge is a copayment payable by you.

How Do I File a Claim for Dental Benefits?

Dental claim forms and instructions are available to dentists in areas where there are GM employes and retirees. However, if your

dentist does not have a claim form, you may obtain one from the GM location where you or your deceased spouse last worked or from your dental carrier.

If a course of treatment is expected to involve dental expenses amounting to $200 or more, your dentist should file with the carrier a description of the procedures to be performed and an estimate of the charges prior to beginning treatment. The carrier will notify the dentist of estimated benefits payable with consideration given to alternate procedures that may be performed in order to accomplish the desired results.

You should discuss the treatment plan, the fee, and the estimated dollar amount of benefits with your dentist **before** treatment begins.

Am I Covered for Vision Care?

Retired employes, surviving spouses, and their eligible dependents (except sponsored dependents) for whom GM contributes the full cost of health care coverages are eligible for vision coverage.

Benefits will be provided for the reasonable and customary charges (less copayment) for:

- vision examination by an ophthalmologist or optometrist once during any period of 12 consecutive months ($7 copayment);
- lenses once during any period of 12 consecutive months ($10 copayment);
- frames once during any period of 24 consecutive months ($10 copayment unless frames are supplied with new lenses in which case one $10 copayment applies to both lenses and frames); and
- contact lenses when vision cannot be corrected to 20/70 in the better eye except by their use or when certain irregularities in the shape of the eye require their use ($10 copayment). When contact lenses are prescribed for any other reason, $35 less the $10 copayment will be the maximum benefit.

Benefits will be provided for the reasonable and customary charges (less copayment) for contact lenses following cataract surgery unless otherwise provided under surgical-medical coverage.

If you want to know when your 12 or 24-month time period ends, count from the date of your last examination, or from the date you ordered the last frames or lenses under the Program, as appropriate.

Under certain limited conditions a benefit may be payable for a second examination within 60 days of the first examination.

If you obtain your frames from a participating provider and you select frames from a display the provider will show you, there will be no expense to you other than the copayment. However, if you select frames not included in the display, or obtain your frames from a non-participating provider, up to $15 less the $10 copayment will be the maximum benefit.

The total copayment for each covered individual during any period of 12 consecutive months will not exceed $17 ($7 for a vision examination and $10 for lenses and frames combined).

How Do I File a Claim for Vision Benefits?

Metropolitan Life Insurance Company is the vision coverage carrier for all retirees and surviving spouses unless you select an HMO that provides vision coverage. A claim form may be obtained from the GM location where you or your deceased spouse last worked or from a participating provider. Complete your portion of the form and have the remaining portion completed by the provider. The completed form should be sent to Metropolitan. Benefits will be paid directly to the provider to the extent that you have not paid all or part of the charges for services. In that case, Metropolitan will pay the provider and/or will reimburse you the appropriate amount.

COMPREHENSIVE MEDICAL

What Is the Comprehensive Medical Expense Insurance Program (CMEIP)?

Comprehensive medical expense insurance coverage provides you, your eligible dependents (except sponsored dependents) and eligible surviving spouse with major medical benefits. This coverage is offered through the Connecticut General Life Insurance Company. It adds to the protection you are provided by the basic coverages described earlier.

You pay part of the cost of this additional coverage, based on the schedule below. General Motors pays the major portion of the cost.

Monthly Contributions as of July 1, 1985	
Coverage	Retiree or Surviving Spouse
	$
Single	3.00
Two Party	8.15
Family	10.70

What Are Major Medical Benefits?

Major medical benefits offer additional protection when the basic benefits described earlier either have been exhausted or are not applicable.

CMEIP covers reasonable charges, less a deductible amount as described later, for necessary medical services and supplies, including those listed which are not generally covered by your basic coverages:

- physicians' non-surgical services out of hospital;
- up to $25 a day toward the difference in cost between a semi-private and a private hospital room;
- professional private duty nursing care (up to $25 a day when care is determined to be primarily custodial in nature);
- blood;
- professional ambulance service when medically necessary;
- semi-private hospital charges after the maximum duration allowed under basic coverages (generally 365 days) has been exhausted;
- semi-private nursing home charges for acute therapeutic care after the maximum duration allowed under basic coverages (generally 730 days) has been exhausted;
- dental work and dentures made necessary by an accident (to the extent not covered under the dental plan);
- inoculations, less amounts payable by basic coverages;
- physical examinations (limited to one per year for persons over age 6) including laboratory tests;
- chiropractic services (up to 20 visits within the initial 3 months of treatment);
- up to $150 a day, less amounts payable by basic coverages, for confinement in a hospital operated primarily for care of nervous or mental conditions; and
- up to $25 a day in an approved facility or for custodial care rendered at home by a professional private duty nurse.

Must I Pay for Part of the Charge for Services?

Under CMEIP you pay a deductible amount of $125 toward covered expenses which are incurred each calendar year for the same individual. This $125 is called the individual deductible amount. In meeting this amount, you can add up all of your covered expenses for the same individual, whether they relate to one condition or to a number of different conditions. However, if covered expense incurred by two or more family members equals or exceeds $250 (the family deductible amount), no additional deductible amount will be applied against expenses incurred by any of your other family members for that calendar year. No more than

$125 of covered expenses for one family member can be applied toward the $250 family deductible amount.

Any covered expenses incurred in October, November or December of any calendar year which are not applied to the deductible amount for that year and for which no benefits are payable may be applied to the deductible amount for the following calendar year. **However, all claims (including those used to satisfy the deductible) must be filed with Connecticut General before the end of the calendar year following the year in which the expenses were incurred. To avoid having expenses excluded, you should file expenses as they are incurred, even if you have not yet met the deductibles.** These services then will be recorded and Connecticut General will advise you when the deductibles have been met.

After Paying the Deductible Amount Are There Any Charges To Me?

After you pay the deductible amount, CMEIP pays 80% of the next $5,000 of covered expenses incurred during one calendar year and 100% of covered expenses which exceed $5,000 (except outpatient psychiatric care). Covered expenses for psychotic conditions are payable at 80%. Covered expenses for outpatient psychiatric care for non-psychotic conditions are payable at 50%.

Are There Any Calendar Year Benefit Limitations?

Yes. Covered expenses for outpatient psychiatric care include only those charges for services rendered after all basic benefits have been exhausted. Reimbursement for non-psychotic conditions is limited to $4,000 per year.

Reimbursement for outpatient allergy testing and treatment is limited to $2,000 per year.

The maximum reimbursement amount is $50,000 per calendar year for each individual. There is no lifetime maximum.

Are There Any Exclusions?

Exclusions include but are not limited to:

- Out-of-pocket expenses incurred because of failure to follow Informed Choice Plan option guidelines;
- Prescription drug copayments; and
- Cosmetic surgery.

A full list of benefit limitations and exclusions appears in your Certificate of Insurance.

How Do I File a Claim Under the Comprehensive Medical Expense Insurance Program?

You previously should have received a booklet "How to File A Claim" which provides instructions and helpful hints on how to file a claim. If you do not have a copy of this booklet, you may obtain one from the location where you or your deceased spouse last worked or from Connecticut General.

You should file a claim when your out-of-pocket expenses exceed the $125 deductible amount for an individual or $250 for your family. To avoid overlooking expenses or having expenses excluded, you should file expenses as they are incurred, even if you have not yet met the deductibles. These services then will be recorded and Connecticut General will advise you when the deductibles have been met. **In any event, claims should be filed no later than the end of the calendar year following the year in which expenses were incurred.**

When you are ready to file a claim, you should obtain the necessary forms from the GM location where you or your deceased spouse last worked or from Connecticut General.

There are things you should do routinely to prepare for filing the claim:

- obtain all bills and receipts for medical services incurred by you and your covered dependents;
- be sure bills and receipts are properly identified, separated by individuals and in chronological order;

- see that bills or receipts are itemized and include patient's name, description of service or medical supply, date of service or purchase, and charges incurred;
- submit basic coverage, and if applicable, Medicare Explanation of Benefit vouchers, with appropriate bills or receipts; and
- be sure that receipts for medical supplies, equipment, private duty nursing, physical therapy, or other services not performed by a physician are supported by certification of the attending physician that such supplies, equipment or services are medically necessary.

If you are in doubt as to whether you should file a claim, you are urged to submit a claim and allow the carrier to determine benefits which might be payable.

MEDICARE

What Do I Need To Know About Medicare Eligibility and Enrollment?

Medicare is a federal health care program for individuals age 65 or older and for certain individuals under age 65 who qualify (1) through receipt of Social Security disability insurance benefits or (2) after three months of dialysis treatment because of total kidney failure. Medicare has two parts, Part A, which provides hospital coverage, and Part B, which provides medical coverage. Enrollment for Part A is automatic. Enrollment for Part B is voluntary and requires a monthly contribution by you which you may have deducted from your Social Security check.

It is your responsibility to contact the local Social Security office to apply for Medicare when you attain age 65. It is suggested this contact be made three months prior to attaining age 65. This will allow sufficient time to process your application so you will not miss your initial opportunity for enrollment.

If you do not enroll for Medicare when first eligible, there may be a penalty in the monthly amount of Medicare Part B premium cost to you for each year you delay enrolling.

What Are My Medicare Benefits?

Medicare Part A can help pay for inpatient hospital care and for care in an approved skilled nursing facility, or in your own home through an approved home health care agency after an inpatient hospital stay.

Medicare Part B can help pay for physicians' services, including home and office calls, outpatient hospital services, physical therapy, speech pathology, ambulance service, and other medical services and supplies.

A booklet containing details of Medicare benefits is available upon request from your nearest Social Security office. It is suggested that you obtain a copy of the booklet and familiarize yourself with the important information contained in it.

What Effect Does Medicare Have on My GM Health Care Benefits?

If you or one of your dependents is enrolled for Medicare, your benefits under the GM Health Care Insurance Program will be reduced by benefits payable for the same services under Medicare. In other words, benefits payable under Medicare will not be duplicated by your GM health care benefits.

It is important for both you and your spouse to enroll for Medicare when first eligible. In the event of your death, your surviving spouse will not be eligible for Corporation contributions for any GM health care coverages if he or she is eligible but not enrolled for Medicare Part B at or after age 65. It is important that you notify GM when you become eligible for Medicare benefits.

How Do Medicare and GM Health Care Benefits Work Together?

The Medicare program has deductible and coinsurance amounts which normally are

payable by you. Your GM Health Care Insurance Program generally pays these Medicare deductibles and coinsurance amounts for you. However, if the deductible or coinsurance amounts apply toward services which are not covered benefits under the GM Program (office calls for example), the GM Program will not pay the applicable deductibles or coinsurance amounts for you.

Will I Get a New Identification Card When I Become Eligible For Medicare?

In most cases, yes. If your health care coverages are provided through a Blue Cross-Blue Shield Plan, you will receive a new health care identification card shortly after you become eligible for Medicare.

Can I Transfer My GM Health Care Coverages If I Move?

Yes. You may change your permanent residence to an area served by a carrier other than the one with which you were enrolled before moving. If your new residence is located in an area served by a GM health care carrier, you may wish to transfer your health care coverages to the carrier that serves the area where you now live. If so, contact the GM location where you or your deceased spouse last worked for information as to how and when a transfer of coverage may be accomplished.

Are Sponsored Dependents Eligible for Health Care Coverage?

Certain dependents may be eligible for sponsored dependent coverage. Generally, sponsored dependents must be related to you. You must be able to claim an exemption for such individuals on your Federal Income Tax Return. You pay the full cost for sponsored dependent coverages. Your sponsored dependents have the health care coverages under the Informed Choice Plan option you elected, except that dental and vision coverages are not available to sponsored dependents. Some HMOs may not accept enrollees with sponsored dependents.

What Information Do I Need to Communicate With the Carriers?

Your Social Security number is always needed if you communicate with any of the carriers. It is helpful if you also provide the name of the location from which you or your deceased spouse retired. If you are a dependent, the Social Security number of the retiree or surviving spouse through whom you are covered is needed.

What Does Coordination of Benefits Mean?

A coordination of benefits (COB) provision is included in all coverages under the GM Health Care Insurance Program. The purpose of this provision is to avoid duplicate payment of benefits in the event an individual is covered by more than one plan. The carrier should be notified of other plans or programs which may cover you or your dependents. If expenses are incurred by a spouse or dependent who is covered by another plan, the other plan may have the primary responsibility of payment. If so, the cost to the GM Program will be reduced. COB is handled between the carriers involved. You may be required to provide the carriers with the necessary information.

Under COB you and your dependents will receive no fewer benefits than you would have received under the GM Program alone.

What Is Subrogation?

In the event that any payment of benefits is made by a health care carrier under the GM Program for services which are legally determined to be payable by a third party, such carrier shall acquire all of the retiree's, surviving spouse's, or dependent's rights of recovery as a result of a settlement or judgment brought against any person or organization, except against insurers on policies issued in the name of the retiree, surviving spouse, or dependent.

Are There Any Exclusions or Limitations With Respect to Health Care Coverages?

Yes. Certain services and charges with respect to health care coverages are excluded or limited. A description of exclusions and limitations applicable to each benefit provided under the GM Health Care Insurance Program may be found in the appropriate program language, benefit certificates and any riders thereto or similar documents provided by the Corporation or the carriers.

Are Certificates Available?

Yes. The foregoing is intended only as an outline of your GM health care coverages. Actual governing provisions and specific exclusions are contained in the applicable program language, benefit certificates and any riders thereto or similar documents provided by the Corporation or the carriers. Certificates will be available to you upon request from the personnel office at the GM location where you or your deceased spouse last worked or from your local Blue Cross or Blue Shield Plan, Metropolitan, or other carrier, as may be applicable.

EXPLANATION OF CERTAIN TERMS APPLICABLE TO HEALTH CARE COVERAGES

Carrier...

any entity through which benefits are paid, services are provided, or coverage is underwritten or administered, including but not limited to General Motors, a Blue Cross-Blue Shield plan, a commercial insurance company, a health maintenance organization, or a preferred provider organization.

Approved Facility or Treatment Program...

a facility or a treatment program that has met criteria established by the carrier to provide certain services covered by the GM Health Care Insurance Program. The following are examples of facilities or treatment programs which must be approved by the applicable carrier in order for benefits to be paid:

- hospitals
- nursing homes
- outpatient psychiatric care facilities
- substance abuse treatment facilities
- outlets for prosthetic appliances
- free-standing physical therapy facilities
- home care programs

If you are not sure as to the approved status of a facility or treatment program, you may seek advice from the personnel office at the GM location where you or your deceased spouse last worked.

Copayment...

a part of the charge for services which you must pay. Most health care expenses are paid in full by the appropriate carrier. However, you must pay part of the charge or a "copayment" for certain services such as outpatient psychiatric care, prescription drugs, dental care and vision care.